TREATMENT PLAN /REQUEST FOR ADDITIONAL SESSIONS

CONCERN BEHAVIORAL HEALTH MANAGEMENT
11121 Kenwood Road
Cincinnati, OH 45242
Fax #: 513-891-0838

Client Name: ____________________________

Insurance ID: ____________________________

Client DOB: ____________________________

DSM-IV DIAGNOSIS (PLEASE COMPLETE ALL FIVE AXES)

Axis I: ____ Axis II: ____

Axis III: ____ Axis IV: ____

Axis V: Current GAF _______________ GAF at First Session _____________ Highest Lifetime GAF _____________

Risk Assessment:

If applicable, CONCERN treatment coordinators are available for consultation regarding alternate levels of care.

	Mild	Moderate	Severe	N/A
Suicidal ideation	☐	☐	☐	☐
Homicidal ideation	☐	☐	☐	☐
Substance use problems	☐	☐	☐	☐

Is client currently taking psychotropic medications? ☐ **yes** ☐ **no**

* **Prescribed by:** ☐ **PCP** ☐ **Psychiatrist**

Requests beyond 1x/week require telephone consultation with a coordinator. Please call 513-891-1691.

Please remember to coordinate care if your client is receiving care from another behavioral health provider.

# of Sessions Requested: __________ **Start Date:** __________ **End Date:** _________________

MD or Clinician Signature: ____ Date: _____________

Print name of MD or Clinician: ____

Address: ____ Phone #: ___________________________________

Fax #: ____